Health Care Quality Improvement

Washington State Diabetes Collaborative II

Learning Session 1	**February 12-13, 2001**
Learning Session 2	**May 7-8, 2001**
Learning Session 3	**September 10-11, 2001**

WASHINGTON STATE DIABETES COLLABORATIVE II

Your partners in improving health care

Washington State Department of Health | PRO-West Quality health care solutions | improving chronic illness care

In this handbook, you'll find information that will help you plan for your participation in the Washington State Diabetes Collaborative II ("the Collaborative").

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Acknowledgments

It is the culture of the Collaborative by nature to openly share and learn from each other's experiences. Many organizations and individuals contributed to the development of this prework packet and the Washington State Diabetes Collaborative II.

We would like to recognize the following organizations for providing Collaborative direction, oversight, financing, and faculty:

- Washington Department of Health Diabetes Control Program, through a cooperative agreement with the Centers for Disease Control and Prevention,
- PRO-West, a private, nonprofit quality improvement corporation, through their contract with the Health Care Financing Administration, and
- The W. A. (Sandy) MacColl Institute for Healthcare Innovation in the Center for Health Studies at Group Health Cooperative of Puget Sound, through the Robert Wood Johnson Foundation National Program for Improving Chronic Illness Care.

The Institute for Healthcare Improvement (http://www.ihi.org) developed the Collaborative learning methodology with colleagues from Associates in Process Improvement. We are grateful for the use of their materials.

The Bureau of Primary Healthcare Diabetes Collaboratives I and II have shared their experiences and materials to enhance the Washington State Diabetes Collaborative.

WSDC I provided many lessons learned for the core leadership and model intervention to improve diabetes care in Washington. Some of the Diabetes I teams have returned to Diabetes II to promote the spread of their team's work within their organizations.

Team Preparation Checklist

- ❑ Review this handbook.
- ❑ Select Pilot sites and team members, and distribute handbook materials. Ask your team to review the prework materials.
- ❑ Convene clinic and/or health plan/clinic team and define aim and measures. Work with your organization's Senior Leader to determine direction for your aim, measures, and the specific population of patients you will be working with during the Collaborative.
- ❑ Complete the Assessment of Chronic Illness Care Survey, Version III (pages 33-44) as a team and fax your results to PRO-West at (206) 368-2419. This must be done prior to your team's individual conference call.
- ❑ Schedule/complete an individual conference call with your team and one of the Collaborative Leaders (please call the Collaborative Coordinator, Melissa Merculief, at (206) 364-9700 x2270 to arrange a time).
- ❑ Register for Learning Session 1 with PRO-West (use the form on page 8 of this handbook or call the registration office at (206) 364-9700 x2270). Also include the $150.00 participant fee for each team member attending Learning Session 1.
- ❑ Contact the Marriott Hotel in Seatac to reserve accommodations (see logistical information in handbook on page 9).
- ❑ Prepare and bring a storyboard to learning session I. See page 27 for more information.
- ❑ Visit the Collaborative's Website http://www.doh.wa.gov/cfh/wsdc (see instructions in prework packet on page 29).

General Information

Overall Structure of the Washington State Diabetes Collaborative

The Washington State Diabetes Collaborative will involve approximately 30 organizations working together intensely for thirteen months. During that time, Collaborative organizations will participate in three 2-day Learning Sessions and maintain continual contact with each other, the Collaborative Leadership Team and faculty members through email, website, conference calls, and site visits. **Note:** *Email, accessing the Collaborative website, and communicating via the WSDC II Listserv, will be the primary means of communication among Collaborative Team Members. We strongly urge those who do not have email to subscribe to an internet service provider for the duration of the Collaborative.* In March 2002, the Collaborative will share its findings and achievements with the greater health care community at the second Washington State Diabetes Collaborative Outcomes Congress that will highlight the accomplishments of the Collaborative and share effective models of diabetes care with the community.

Learning Sessions

Learning Sessions are the major integrative events of the Collaborative. Through plenary sessions, small group discussions, and team meetings attendees have the opportunity to:

- Learn from faculty and colleagues
- Receive individual coaching from faculty members
- Gather new knowledge on the subject matter and process improvement
- Share experiences and collaborate on improvement plans
- Problem-solve improvement barriers

Schedule for the Learning Sessions

Learning Session 1	*Learning Session 2*	*Learning Session 3*	*Washington State Diabetes Collaborative Outcomes Congress*
February 12-13, 2001	May 7-8, 2001	September 10-11, 2001	March 11-12, 2002
The Marriott Hotel	The Marriott Hotel	The Marriott Hotel	The Marriott Hotel
Seatac, WA	Seatac, WA	Seatac, WA	Seatac, WA

Between Learning Sessions

The time between Learning Sessions is called an **Action Period**. During Action Periods, Collaborative Team Members work within their organizations to test and implement a new organizational approach to caring for people with diabetes. Although participants focus on their own organizations, they remain in continuous contact with other teams enrolled in the Collaborative, Collaborative Leadership Team, and faculty. This communication takes the form of conference calls, email through the listserv, website, and site visits to other organizations in the Collaborative. In addition, Collaborative Team Members share the results of their improvement efforts in monthly Senior Leader Reports. Participation in Action Period activities is not limited to those who attend the Learning Sessions. We encourage and expect the participation of other team members and support persons in your organization in Action Period activities.

Collaborative Timeline

December 2000

- 15th – Memorandum of Understanding to the Department of Health and Pre-Registration Form to PRO-West
- 28th – Mail Pre-Work Packet and begin activities and preparations for February 12-13, 2001 meeting

February 2001

- 1st– 11th – Schedule/Complete phone call with Collaborative Leadership Team and clinic and/or health plan/clinic team
- 1st – Reserve hotel rooms
- 7th – Registration forms and fee due to PRO-West
- 12th-13th –Washington State Diabetes Collaborative II Learning Session 1 (Seatac, WA)
- 14th – First Action Period begins

March 2001

- 15th – Senior Leader Report due to PRO-West
- 20th – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

April 2001

- 15th – Senior Leader Report due to PRO-West
- 17th – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

May 2001

- 2nd – Registration Deadline for LSII
- 7th – 8th Washington State Diabetes Collaborative II Learning Session 2 (Seatac, WA)
- 9th – Second Action Period begins
- 15th – Senior Leader Report due to PRO-West
- 22nd – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

June 2001

- 15th – Senior Leader Report due to PRO-West
- 19th – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

July 2001

- 15th – Senior Leader Report due to PRO-West
- 17st – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

Collaborative Timeline (continued)

August 2001

- 15th – Senior Leader Report due to PRO-West
- 21st –Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

September 2001

- 5th – Registration Deadline for LS III
- 10th-11th – Washington State Diabetes Collaborative II Learning Session 3 (Seatac, WA)
- 12th – Third Action Period begins
- 15th – Senior Leader Report due to PRO-West
- 18th – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

October 2001

- 15th – Senior Leader Report due to PRO-West
- 16th – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

November 2001

- 15th – Senior Leader Report due to PRO-West
- 20th – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

December 2001

- 15th – Senior Leader Report due to PRO-West
- 18th – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

January 2002

- 15th – Special in-depth Senior Leader Report due to PRO-West
- 22nd – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

February 2002

- 15th – Senior Leader Report due to PRO-West
- 19th – Monthly conference call from 12:00 PM – 1:00 PM with Collaborative Team, Health Plan, and Leadership Team

March 2002

- 6th – Registration deadline for Outcomes Congress
- 11th-12th – Washington State Diabetes Collaborative II Outcomes Congress (Seatac, WA)
    - Present team findings
    - Open to community

Register for the Learning Session:

Mail completed form and participant fee to:

PRO-West
10700 Meridian Ave. N., Suite 100
Seattle, WA 98133
Attn: Melissa Merculief, RHIA
Project Coordinator

Conference Location:

Seattle Mariott Sea-Tac Airport
3201 South 176th Street
Seattle, WA 98188
USA
Phone: 1-206-241-2000
Fax: 1-206-248-0789
Toll Free: 1-800-643-5479

This form DOES NOT secure overnight reservations. Reservations for overnight accommodations are made directly with the Seattle Marriott. See the attached information sheet for details on accommodations and transportation.

Each team member attending Learning Session 1 must complete this form and include $150.00 participant fee. (One-day participant fees are unavailable.) Those attending the Learning Session as an observer must include a $200.00 observer fee. Please make your check payable to PRO-West. Make checks payable to PRO-West. Registration forms and fee must be received by PRO-West no later than February 7, 2001.

Last Name First Name Degree

Title

Organization (Please Do Not Abbreviate)

Address

City State Zip

Phone Fax

Email

Learning Session 1 Accommodations, Transportation, and Continuing Education Information

Remember to submit your Registration form and fee to PRO-West by February 7, 2001. If you have any questions, please contact the Project Coordinator at (206) 364-9700 x2270.

Location of the Learning Session

Seattle Marriott Hotel Sea-Tac Airport
3201 South 176th Street
Seattle, WA 98188
Phone: 1-206-241-2000
Fax: 1-206-248-0789
Toll Free: 1-800-643-5479

Dates/Times:

Start: Monday, February 12, 2001
7:30 a.m. Registration/Storyboard Set-Up
End: Tuesday, February 13, 2001
No later than 4:30 p.m.

Participant and Observer Fees

A participant fee of $150.00 is required for each Collaborative participant. ***A fee of $200.00 is required for each observer.*** This fee includes meals and use of the meeting facilities. Please make checks payable to PRO-West and send to the following address:

PRO-West
10700 Meridian Ave. N., Suite 100
Seattle, WA 98133
Attn: Melissa Merculief, RHIA
Project Coordinator

Overnight Rooms

Overnight accommodations are available on-site at the Seattle Marriott at Seatac Airport. For reservations, please call 206-241-2000 or 800-643-5479. When making your reservations, identify yourself as an attendee to the Washington State Diabetes Collaborative.

Single/Double Room: $129.00 plus tax **per night, for the nights of February 11th and 12th, 2001**.

Please reserve your rooms by February 1, 2001. Room rates will increase to $139.00 per night after February 1, 2001.

Airport Transfer

The Seattle Marriott provides complimentary shuttle services to the hotel. The Shuttle runs every 15 minutes and continuously circles the airport for pick-up at island 2 on level 3. The Shuttle can be picked up at the Marriott on the circular drive outside the check-in desk..

Continuing Education Credit

Continuing Education Credit is being obtained for Physicians, Nurses, and Pharmacists. Continuing nursing education credits co-sponsored by Northwest Hospital.

NORTHWEST HOSPITAL

Collaborative Goal, Vision, Model, Structure, and Required Measures

Impact of Diabetes

National

In 1995, nearly 100 million people in the United States had some type of chronic illness. Almost half of those people experienced difficulties in their daily life due to illness. It is estimated that 470 billion dollars were spent in 1990 caring for people with chronic conditions. Numerous surveys and audits have documented shortcomings of practitioners in complying with well-established guidelines for the clinical aspects of care for patients with chronic disease. Providers feel unprepared and too rushed to meet the educational, clinical, and psychological needs of chronically ill patients and their caregivers. Patients experience care that is uncoordinated, impersonal, and unsupportive, which may leave them feeling incapable of meeting the day-to-day needs of living with a chronic condition.

State

Diabetes is associated with a substantial toll in morbidity, mortality, and economic costs in Washington State. An estimated 208,000 Washington residents have diagnosed diabetes, and approximately 109,000 are thought to have undiagnosed diabetes. Diabetes accounts for over 3,000 deaths per year in Washington State and is the leading cause of blindness. Yearly, almost a thousand Washington residents experience amputations of the lower extremities because of diabetes, and diabetes accounts for nearly 300 cases of kidney failure requiring lifelong dialysis or kidney transplant. Annually, there are over 49,000 diabetes-related hospitalizations in the state, accounting for nearly half a billion dollars in hospital costs. In total, diabetes accounts for nearly two billion dollars in direct and indirect costs each year.

Shifting Healthcare Environment

Fundamental changes are underway in American medicine. Healthcare systems are replacing independent small practices. Managed care and integrated delivery systems are leading an aggressive pursuit for lower costs and greater efficiency. Greater emphasis is being placed on the value of services, receiving high quality services for a competitive price. Measurement systems and "report cards" are a common feature of today's marketplace. Health plans are purchasing disease management programs to try to reduce the costs of high-risk populations. There is also a growing gap in health disparities among the diverse U.S. population.

Goal

> ***Improve the quality of care delivered to patients with diabetes in a cost-effective manner through partnerships and collaborations using proven, evidence-based practices.***

Vision

The Washington State Diabetes Collaborative II will work together for thirteen months to implement a model of care for people with chronic conditions, targeting diabetes. The principles used to improve care for this chronic condition will serve as a template for managing a variety of chronic illnesses. We will strive to meet the Collaborative goal and your targeted measures by (1) sharing ideas and knowledge, (2) learning and applying methodology for organizational change, (3) system-wide implementation of a chronic care model with related proven concepts, and (4) measuring progress. Methodology for spreading organizational change across the health system will be stressed as well. The clinical priorities of this chronic condition are based on currently available scientific evidence.

Participants in this Collaborative will learn and implement an organizational approach to caring for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, and evidenced-based interactions between an informed, activated patient and a prepared, proactive practice team.

Model

The model for this Diabetes Collaborative combines an interactive process improvement approach with rapid cycle change using the Chronic Care Model. This model has been successfully implemented in over 300 clinics nationwide to improve the care of patients with diabetes, asthma, and depression. Another distinctive feature of this Collaborative is the focus on patients' needs and self-management abilities as drivers of health change efforts. By taking a redesign approach, results will be achieved by "organization-wide" as opposed to "within one department or area". This strategy assumes that clinics are not bound by the current system, that they can affect changes identified as useful, and that they desire a system that is efficient, effective, and satisfying for both patient and staff.

Structure

Each clinic and/or health plan/clinic team is expected to identify a specific population of diabetes patients that can be monitored for the duration of the Collaborative. This is called the pilot site or pilot population and is defined by a specific group of clinics/practitioners/locations. A patient database (simple or sophisticated) must be available during the Collaborative to document and track results of interventions. Participating teams must be open to changing actions and systems in order to improve clinical management and office efficiency. The Collaborative Leadership Team and faculty will aid participating organizations to capitalize on the learning and improvement from the focused project by coaching senior leaders in those organizations to develop a system for spreading the practice redesign to other locations/offices/clinics.

Required Measures

At a minimum, each team is required to report on the four required measures below. Other measures may be chosen based on identified opportunities for improvement from your baseline chart audit or administrative data reports. The measures below do not represent *ideal* targeted thresholds, but focus more on those patients who have *adequate* thresholds.

The percent of the pilot diabetes population with:

- **An HbA1c below 9.5 %**
- **A blood pressure below 140/90**
- **An LDL cholesterol below 130 mg/dl**
- **A documented self-management goal**
-

If the clinic is working with a health plan and selects additional measures, these measures must be defined together.

Collaborative Expectations

What Clinics can expect from participation in this Collaborative:

Over the life of the Collaborative, clinics can expect a competitive advantage to result from:

- **Satisfied patients –** by enhancing the quality of interaction with staff focused on their chronic disease.
- **Enhanced productivity** of providers and staff by reducing the rework, eliminating waste, and simplifying the system.
- **Reduced cost** by increasing provider and staff productivity, developing pro-active, informed patients, and improving morbidity.
- **Extensive technical assistance** in the area of quality management and disease management.

Clinics are expected to:

- Management/Senior Leaders of the Collaborative must be unwavering. It is important for management to understand that the Collaborative is a destabilizing force (since systems cannot remain as they are) but the team can be successful. It is therefore normal that some staff will resist initial efforts to redesign the system. These same people are likely to become your champions and enthusiastic supporters as results of the work are seen and promoted. The success of the team is directly proportional to the support they receive from their Senior Leadership. Senior Leaders are expected to attend at least Learning Session I, Learning Session III, and the Outcomes Congress. Senior Leaders take the lead responsibility of spreading the system changes throughout the clinic system;
- Select a team of at least three people: one senior leader in the organization, one member representing administration (usually the Day-to-Day Leader) and one innovative clinician with an interest in diabetes (the Clinical Champion). For example the Clinical Champion could be an MD, RN, RD, RPh, NP, PA;
- Use rapid change cycles (Plan-Do-Study-Act tests) to implement the Chronic Care Model and report progress toward identified measures;
- Make well-defined measurements, relating to their aim, at least monthly and plot them over time for the duration of the Collaborative. Key interventions/changes in the measures will be annotated on these graphs;
- Submit monthly Senior Leader Reports to PRO-West using specific reporting forms, delineating progress toward identified required and clinic-specific measures. If working with a health plan, collaborate on the submission of the monthly report (See Appendix C);
- As a team, participate in each of three 2-day Learning Sessions and the 2-day Outcomes Congress, beginning February 2001 and ending March 2002. (February 12-13, 2001, May 7-8, 2001, September 10-11, 2001, and March 11-12, 2002). Expenses include travel, lodging, meeting registration of $150 per person per Learning Session, and dedicated staff time to implement changes determined necessary to reach desired measures;
- Define, with your clinic team, specific diabetes goals you wish to achieve;
- Report on the required process and outcome measures of the Collaborative:
  The percent of the pilot diabetes population with
  - an HbA1c below 9.5%
  - a blood pressure below 140/90
  - an LDL cholesterol below 130 mg/dl
  - a documented diabetes self-management goal

  If the clinic is working with a health plan, the additional measures must be defined together;
- The clinic will work to spread the improvements achieved through participation in the Collaborative throughout its administrative structure of the clinic;
- Present storyboards illustrating progress at each Learning Session and the Outcomes Congress;

- Use rapid change cycles to implement the Chronic Care Model and report progress toward identified process and outcome measures;
- Participate in the communication network established by PRO-West to provide support throughout the Collaborative;
- Report on the achievement of selected process and outcome measures at the Outcomes Congress in March 2002. If working with a health plan, report measures together;
- Participate in the national evaluation of the Chronic Care Model coordinated by RAND Health if:
    - your pilot population exceeds 150 and you have more than 150 people with diabetes not in your pilot population and;
    - you received administrative approval from your clinic to participate;
- Maintain and safeguard the confidentiality of privileged data or information, written, photographed, or electronically recorded, generated and/or acquired by the clinic, which can be used to identify an individual patient, practitioner, participating provider organization, facility, health plan or patient population.

Health Plans are expected to:

- Select a team of at least two people representing the suggested categories of administration, medical director, and quality coordinator. (If the Health Plan participated in the Washington State Diabetes Collaborative I, only one person on the team needs to be at the Learning Sessions);
- Provide a Senior Leader to serve as sponsor for the team working on the Collaborative, serve as champion for spread of the changes within their health care system, and attend at least the first and third Learning Sessions and the Outcomes Congress;
- Select a clinic partner, through which the plan does business, to participate in the Collaborative;
- Participate in each of three, two-day Learning Sessions and the two-day Outcomes Congress beginning February 2001 and ending March 2002 to be held in the Sea-Tac area. (February 12-13, 2001, May 7-8, 2001, September 10-11, 2001 and March 11-12, 2002);
- Health plan expenses will include travel, lodging, $150 registration per person per Learning Session and dedicated staff support to assist clinic partner;
- Define, with your clinic partner, the specific diabetes outcomes for your health plan/clinic team;
- Report on the required process and outcome measures of the Collaborative:
    The percent of the pilot diabetes population with
    - an HbA1c below 9.5%
    - a blood pressure below 140/90
    - an LDL cholesterol below 130 mg/dl
    - a documented diabetes self-management goal;
- Facilitate and provide support for your clinic partner in implementing the Chronic Care Model to achieve lasting change within the clinic delivery system;
- Assist in the completion of monthly Senior Leader Reports to PRO-West identifying progress and rapid change cycles implemented. (See Appendix C) Assist clinic partner in the creation of storyboards for presentation at each Learning Session and the Outcomes Congress;
- Participate in the communication network established by PRO-West identifying progress and storyboards with clinic partner for presentation at each Learning Session and the Outcomes Congress;
- Maintain and safeguard the confidentiality of privileged data or information, written, photographed, or electronically recorded, generated and or/acquired by **{insert health plan name}** which can be used to identify an individual patient, practitioner, participating provider organization, facility, health plan, or patient population.
- CHANGE IN STATUS - In the event of substantive change in the legal status, organizational structure, or fiscal reporting responsibility of the Health Plan, Health Plan agrees to notify DOH project manager of the change. Health Plan shall provide notice as soon as practicable, but no later than thirty days after such a change takes effect.

The Collaborative Leadership Team will:

- Provide evidence-based information on subject matter, application of that subject matter, and methods for process improvement, both during and between Learning Sessions;
- Offer coaching to organizations;
- Provide communication strategies to keep organizations connected to the Collaborative Leadership Team, faculty, and colleagues during the Collaborative;
- Provide information on status of teams;
- Create a fun learning environment for each learning session;
- Meet weekly to coordinate the Collaborative.

The Department of Health will:

- Provide leadership, coordination and partial funding for three, 2-day Collaborative Learning Sessions and a 2-day Outcomes Congress, a reporting structure, data analysis, marketing and promotion, technical support to teams and communication methodologies;
- Document in-kind support provided by all participants in the Collaborative;
- Sign a Memorandum of Understanding with each participating team, health plan, and supporting organization;
- Promote participation in the Collaborative and follow-up on all issues related to the administration of the Collaborative;
- Provide technical support to teams to implement the Chronic Care Model;
- Execute a contract partnering with PRO-West to market the Collaborative, enroll teams, coordinate the delivery of the Learning Sessions and Outcomes Congress, review and score the team monthly reports, provide technical assistance to the teams, maintain a communication system, provide data analysis, and faculty support;
- Execute a Memorandum of Understanding with the MacColl Institute for Healthcare Innovation/Group Health Cooperative of Puget Sound to provide faculty and materials for each Learning Session and the Outcomes Congress, technical assistance to project teams, marketing support, and consultation with the Leadership team to coordinate the Collaborative;
- Execute a Memorandum of Understanding with RAND Health to enroll and facilitate participation of the clinics in the Improving Chronic Illness Care evaluation;
- Promote the process and outcome measures of the Collaborative to local, state and national forums and the media;
- Conduct regular conference calls with the Leadership team to provide oversight to the project;
- Assure adherence to internal confidentiality procedures during the course of the Collaborative. These procedures apply to monthly activity reports, technical consultation, design of the Collaborative communication system, written reports and all data or information, written, photographed or electronically recorded, generated and/or acquired by DOH which can be used to identify an individual patient, practitioner, participating provider organization, facility, health plan or patient population;

PRO-West will:

- Register health plan and/or clinic teams for three, 2-day Collaborative Learning Sessions in February 2001, May 2001, September 2001 and a 2-day Outcomes Congress in March 2002;
- Plan and implement each Learning Session and the Outcome Congress including:
    - Develop the agenda in consultation with DOH, the Improving Chronic Illness Care national program and Collaborative faculty.
    - Provide on-site support to facilitate each Learning Session and the Outcomes Congress
    - Coordinate all speakers

- Assemble all handout materials
- Coordinate storyboard set-up
- Coordinate on-site arrangements and payment to the facility;

- Facilitate receipt, analysis and scoring of monthly reports from participating teams, which will track individual team progress toward required, and team selected measures;
- Monitor the progress of each team providing consultation to achieve the measures selected by the team;
- Maintain a communication system for the participating teams to share resources and problem-solve;
- Participate in all Leadership team conference calls;
- Report at the Learning Sessions and Outcomes Congress the progress toward the overall process and outcome measures of the Collaborative to improve glycemic control, blood pressure control, lipid control, and self-management support;
- Assure adherence to internal confidentiality procedures during the course of the Collaborative. These procedures apply to monthly activity reports, technical consultation, design of the Collaborative communication system, written reports and all data or information, written, photographed or electronically recorded, generated and/or acquired by PRO-West which can be used to identify an individual patient, practitioner, participating provider organization, facility, health plan or patient population;

Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation at the MacColl Institute for Healthcare Innovation in the Center for Health Studies at Group Health Cooperative of Puget Sound will:

- Participate in selected Leadership conference calls to provide consultation for the coordination of the Collaborative;
- Provide faculty support for three, 2-day Learning Sessions and the 2-day Outcomes Congress. (February 12-13, 2001, May 7-8, 2001, September 10-11, 2001 and March 11-12, 2002);
- Provide the Chronic Care Model and templates for the content of Learning Sessions 1,2,3 and the Outcomes Congress that addresses the Chronic Care Model and rapid cycle quality improvement methodology;
- Provide consultation for the development of the agenda for each Learning Session and the Outcomes Congress;
- Maintain an active literature review of evidence-based interventions to promote the implementation of the Chronic Care Model;
- Maintain and safeguard the confidentiality of privileged data or information, written, photographed, or electronically recorded, generated and/or acquired by MacColl Institute of Healthcare Innovation which can be used to identify an individual patient, practitioner, participating provider organization, facility, health plan or patient population;

RAND Health will:

- Enroll teams that meet specific size criteria into the National Evaluation;
- Assist the clinic to set up their diabetes registry and identify their diabetes population;
- Assist clinic teams in the abstraction of patient data to populate their diabetes registry;
- Submit Institutional Review Board applications for approval;
- Provide assistance in obtaining patient consent for the patient survey;
- Provide at the end of the Collaborative detailed information about the clinic's progress in the Collaborative including deidentified patient outcomes;
- Provide at the end of the Collaborative deidentified summary information about the other sites in the evaluation program of the Collaborative for benchmarking progress and spreading successes to

other patients and providers; Release survey and chart review instruments for future monitoring of progress

- Maintain and safeguard the confidentiality of privileged data or information, written, photographed, or electronically recorded, generated and/or acquired by RAND Health which can be used to identify an individual patient, practitioner, participating provider organization, facility, health plan or patient population;
- Cover costs related to participating in the evaluation;

For data collection related to the evaluation, the clinic will assist RAND in gaining access to patients and other information sources so that RAND can:

- Collect data on processes and outcomes of patient care using patient surveys, chart review, and administrative records;
- Survey staff to measure organizational and team characteristics relevant to quality improvement.

Collaborative Leadership Team

Collaborative System Leader
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Pre-Work Activities for the February 12-13, 2001 Learning Session I

To prepare for the kick-off conference in February, clinics will work with their partnering health plans (if appropriate) and Collaborative Leadership Team to complete the following tasks:

1. Create the diabetes team
2. Define the aim
3. Identify your pilot population
4. Select and define measures other than the four required measures (optional)
5. Complete the Assessment for Chronic Illness Care Survey (see Appendix B, pg. 33)
6. Complete a conference call with a member of Collaborative Leadership Team
7. Prepare a storyboard

1. Create the Diabetes Team

Creating the Team: Having an appropriate and effective team is a key component of successful improvement efforts. Choose your team members based on their knowledge of, and involvement in, the processes that will be affected to achieve your measures.

Your improvement team should be larger than just the three individuals who attend the Learning Sessions, but not so large as to make it difficult to get work done. Five or six individuals is a good size for the team. The team should have representation from three different dimensions: senior leadership, clinical/technical expertise, and day-to-day leadership. There may be one or more individuals on the team who fit each dimension, and one individual may fill more than one role, but each component should be represented to successfully drive change in your organization.

Pilot Site Team	Functional Title	Characteristics
	Senior Leader	Principal investigator at the pilot site
	Clinical Champion	Clinical Champion and Subject matter expertise
	Day-to-Day leader	Project Coordinator, Report Writer
Support Individuals For teams		
	Finance and Reimbursement	
	Information Systems	
	Medical and Clinical Affairs	
Organization Leadership		
	System Leader	System aim, investment, return, and oversight
	Principal design leader	Vision of the new system for the organization
	Spread leader	Management of spread of changes throughout the organization

Senior Leader

A senior leader is one with enough clout in the organization to institute change and has the authority to allocate the time and resources necessary to achieve the team's aim. It is important that this person have authority over all areas that are affected by the change. Examples of an appropriate senior leader include a Vice President for Clinical Services, Medical Director, or a Division Head.

The senior leader is also expected to be the champion for the spread of the changes throughout the clinics/medical practices in your organization. This senior leader should attend at least the first and third Learning Sessions, participate in the sessions on spread, and attend the Washington State Diabetes Collaborative Outcomes Congress at the end of the Collaborative.

Clinical Champion

A clinical champion is one who knows the subject matter intimately and who understands the processes of care. Additional technical support may be provided by an expert on improvement methods who can help the team determine what to measure, assist in the design of simple, effective measurement tools, and provide guidance on the design of tests.

It is critical to have at least one clinical champion on the team. This champion should have a good working relationship with colleagues and with the day-to-day leader(s) described below, and be interested in driving change in the system. Look for clinicians who are opinion leaders in the organization (individuals sought out for advice who are not afraid to test change).

Day-to-Day Leadership

The day-to-day leader will be the critical driving component of the project, assuring that cycles of change are tested and implemented and overseeing data collection. It is important that this person understand not only the details of the system, but also the various effects of making change(s) in the system. This individual also needs to be able to work effectively with the clinical champion(s).

The day-to-day leader will be the "key contact" at your organization. This individual should be responsible for coordinating communications between the team and the Leadership Team.

Team Members to Send to the Learning Session

At a minimum, choose the three individuals who can most effectively work together, learn the methodology, and plan for action upon return to your institution. These representatives need not be the same individuals each time, but past teams have generally found it most helpful to do so. We have developed the following guidelines from past Collaboratives to help you determine who should attend the Learning Sessions.

- The Day-to-Day Leader(s);
- The Clinical Champion;
- Other clinical leaders, if different from the clinical champion; and
- The Senior Leader should be at the first and third Learning Sessions in February 2001 and September 2001 and the Washington State Diabetes Collaborative II Outcomes Congress in March 2002.

2. Define the Aim

The Model for Improvement is based on three fundamental questions:
(1) What are we trying to accomplish?
(2) How will we know that a change is an improvement?
(3) What changes can we make that will result in an improvement?

The first question is meant to establish an aim for improvement that focuses group effort on using data and information about patients and what other customers, such as payers, believe are important to help define an aim. The Aim Statement should be as concise as possible. Sometimes a team must test an aim before it becomes truly focused.

Set an AIM
An aim is an explicit statement summarizing what your organization hopes to achieve during the Collaborative. It helps to focus on specific actions or elements of the Chronic Care Model, and to define which patients and providers will participate. An aim should also be time-specific and measurable. An example of an aim consistent with the goals of this Collaborative is:

> **Example:** The office practice at Neighborhood Health Clinic will be redesigned so that over 70% of the patients with diabetes will have their last blood pressure below 140/90; 90% will have an HbAlc less than 9.5 %; 70% will have an LDL cholesterol less than 130 mg/dL; and 80% will have a documented self management goal.

In setting your team's aim, be sure to do the following:

1. **Involve senior leaders and health plan partner (if appropriate)**
   Leadership must align the aim with strategic goals of the organization.

2. **Base your aim on clinic and/or health plan data or organizational needs**
   Examine data within your organization or health plan partner. Refer to the Collaborative Goal statement, and focus on issues that matter. Your aim must at least focus on improvement of glycemic control, blood pressure control, LDL cholesterol, and self-management support. *See section on Measures on page 22.*

3. **State the aim clearly and use numerical goals**
   Teams make better progress when they have an unambiguous, specific aim statement. Setting numeric targets clarifies the aim, helps to create motivation for change, and directs measurement. For example, an aim to "increase the percentage of patients with self-management goals to 50%" will be more effective than an aim to "improve patient self-management practices."

3. Identify your Pilot Population

Who are your patients with diabetes? Before tackling a measure, the clinic must know the population of its patients with diabetes. The Diabetes Collaborative shares a common definition of these patients (see page23).

One important requirement for this Collaborative is that a patient population is identified, and a database or registry is established for the patient population. Ideally, you should establish this registry prior to the first Learning Session. Use a database program, a spreadsheet program, or develop a patient list on paper. This registry should include patient demographic data, primary care physician, and clinical findings related to the diabetes targets of the Collaborative at a minimum. This registry is a basic part of the clinical information system that will be part of your practice redesign, and it will also be used to develop measures during the Collaborative.

Steps for developing a diabetes registry and a sample diabetes registry form are included in Appendix D.

4. Select and Define the Measures Other Than Four Required Measures (optional)

The Why, What, and How Much of Measurement
This Collaborative is about improvement of care for people with diabetes, not measurement. But measurement will play several important roles throughout the Collaborative. Measurement will help us evaluate the impact of changes made to improve delivery of care to the population of persons with diabetes. Always remember that measurement should be designed to accelerate improvement, not slow it down. Your team needs just enough measurement to be convinced that the changes you are making are leading to improvement.

Population-based Care Measurement
The Chronic Care Model is designed to drive population-based care (see Appendix A). Population-based care is the delivery of care to all people in the defined population not just to those who choose to access the system.

Identifying the patient population is the backbone to the population-based care delivery system. Without identification of the members of the population, the changes cannot be measured. To identify members, a clinic and/or health plan/clinic team needs to be able to access data that can distinguish populations with different health care conditions. ICD-9 or CPT codes from billing data are the most common source for making these distinctions. The ability to link billing codes to individual patients allows lists to be generated to validate, contact, and track patients for delivery of proven interventions, and to monitor their progress over time.

The Collaborative Leadership Team recommends using NCQA's HEDIS® 2000, Volume 2, Technical Specifications to identify patients with diabetes. A brief definition is provided below:

Data Definition of Diabetes Population
Patients with diabetes (Type 1 and Type 2) age 18 through 75 years old, who were continuously enrolled during the measurement year, and who have at least one visit to the clinic within the past calendar year are considered clinic patients unless there is documentation that the patient has transferred to another practice or has moved from the area. In addition, clinics with managed care plans should try to include in the denominator, patients with diabetes who have **no** documented medical visit to the clinic, and who have been assigned to the clinic for 12 months, with no more than a 45 day drop in coverage.

Required Measures of the Collaborative
There are four required measures for the Collaborative. They are the percent of the pilot diabetes population with:

- An HbA1c below 9.5 %
- A blood pressure below 140/90
- An LDL cholesterol below 130 mg/dl
- A documented self-management goal.

Additional measures may be established based on improvement opportunities you identified in your pilot base-line assessment. Clinics partnered with health plans should define additional measures together.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Measures Related to Your Aim

Measures will provide the means to assess progress toward your aim. Some examples of measures are provided below:

Example 1: 90% of the diabetes clinic patients will have an HbA1c less than 9.5%.

Example 2: 70% of the diabetes clinic patients will have blood pressure less than 140/90.

Example 3: 70% of the diabetes clinic patients will have a LDL cholesterol less than 130 mg/dl.

Example 4: 70% of the diabetes clinic patients will have a documented self-management goal.

Percentages should be established based on baseline chart audit data or administrative data reports. Targeted goals for these measures should beset as stretch goals to be achieved by the end of the 13-month Collaborative.

Additional Measures

In addition to the four required measures, your team may want to select one to three more measures. Consider utilizing the NCQA HEDIS® measures for diabetes (provided below) as your additional measures:

- Hemoglobin A1c (HbA1c) tested
- HbA1c poorly controlled (>9.5%)
- Lipid profile performed
- Dilated eye exam performed
- Kidney disease (nephropathy) monitored

In addition, you could choose from measures provided on the following page.

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Measures of Diabetes Population Appropriate for this Collaborative

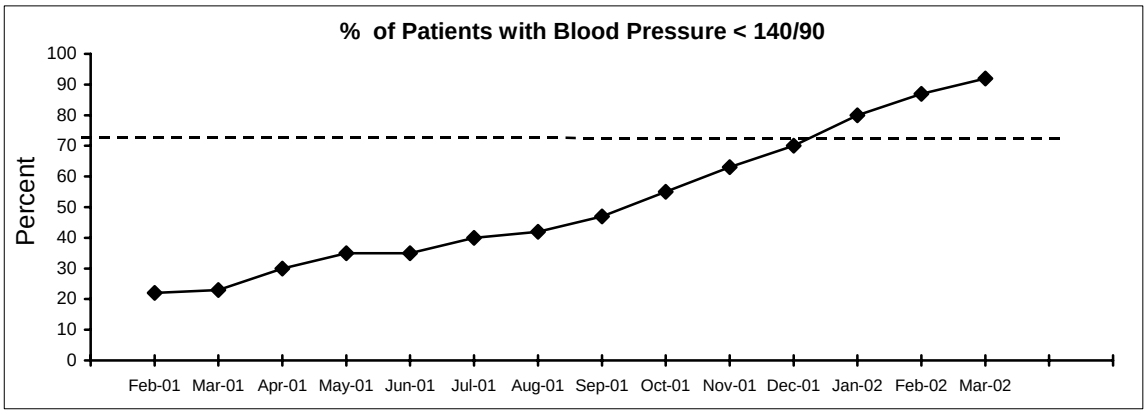
Measure	Population Statistic	Typical Levels	Appropriate Goal
Glycemic Control			
Average HbA1c	% of diabetes population	>9.0	<8.0
*Patients with HbA1c < 9.5	% of diabetes population	<70	>80
Blood Pressure			
*Patients with BP < 140/90	% of diabetes population	<50	>70
Patients with BP < 135/85	% of diabetes population	<40	>60
Self Management			
Evidence of comprehensive education assessment	% of diabetes population	<25	>75
*Documentation of self-management goal	% of diabetes population	<20	>70
Documentation of patient achieving one behavior change goal	% of diabetes population	<10	>50
Cardiac Risk Reduction			
Taking aspirin	% of diabetes population over 40	<50	>80
Smoking status documented	% of diabetes population	<50	>95
Smokers offered cessation help	% of smokers in diabetes population	<50	>90
Patients with fasting lipid profile	% of diabetes population	<70	>95
*Patients with LDL < 130	% of diabetes population	<40	>70
Screening for Complications			
Dilated eye exam in past year	% of diabetes population	<30	>70
Foot exam in the past year	% of diabetes population	<30	>90
Documented foot care intervention	% of high risk foot population	<50	>90
Microalbuminuria screening in last year	% of diabetes population	<30	>50
Other Measures			
Patient satisfaction with care	Average rating or % high rating on survey		
Inpatient Days	Total days per 100 patients in population		
Primary care visits	Average # of visits per patient in population		
Specialty visits	Average # of visits per patient in population		
Pharmaceutical costs	Average annual cost/ patient in population		
Total medical costs per patient	Median of diabetes population for past year		

** All teams must incorporate measures on glycemic control, blood pressure control, LDL cholesterol control, and self-management goals into their measurement strategy.*

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

The minimum standard to monitor the progress of your team throughout the Collaborative is an annotated run chart of key measures of clinical process and outcome measures related to your aim. (See Run Chart.) Data points should be plotted weekly, biweekly, or monthly on the run chart. The following run chart is one example of appropriate presentation of a measure for the Collaborative. Annotations on the graph should include changes that are being evaluated or implemented as well as other circumstances that could impact service levels.

Run Chart



Your patient database (registry) will be key to establishing population-based measures for use in the Collaborative. It is important to begin collecting data prior to the first Learning Session. This will help your team establish specific measures appropriate for your clinic. At the learning sessions, we will discuss ongoing measurement strategies. Expect to continue plotting measurements on a biweekly or monthly basis throughout the Collaborative.

5. Complete the Assessment of Chronic Illness Care Survey, Version III (See Appendix A)

Traditional chronic disease care in the United States, such as diabetes, is often managed from the acute-care model and the provider point of view, as opposed to the patient and family perspective. To improve the quality of care, the Diabetes Collaborative is applying the Chronic Care Model to support the clinical team and patient for improved clinical and functional outcomes.

The Assessment of Chronic Illness Care Survey, Version III (in Appendix B) is designed to help the clinic team understand how the Chronic Care Model relates to the actual clinical practice, and to the experience of patients in the clinic. This assessment tool is invaluable in describing the clinic structures and processes that support strong diabetes care, as well as identifying gaps in chronic disease care. Consequently, the assessment survey is also very useful for the clinic team in formulating their aim statement and measures. **Please complete the Assessment of Chronic Illness Care Survey, Version III and fax this survey to the designated contact (see Survey). The results of this assessment can be discussed with the Collaborative Leadership Team member during your one-on-one conference call prior to Learning Session 1.**

6. Complete a Conference Call with a Leadership Team Member

Call Melissa at 206-364-9700 x2270 when your team has completed the Assessment of Chronic Illness Care Survey, Version III to schedule your conference call.

7. Prepare A Storyboard

Each Learning Session is designed to create an environment conducive to sharing and learning from each other's experiences. At the first Learning Session in February, each organization will receive a 30-in. x 40-in. foam core board, pushpins, tape, an easel, and other supplies on-site, so that your team can present what you have accomplished and learned so far.

Your audience consists of other clinic teams, the Collaborative Leadership Team, observers, and faculty who are not familiar with your aim, measures, and work. Therefore, the storyboard should be as clear and concise as possible.

Storyboard Contents

- A brief description of your organization
- ebers of your tea
- our teas ai and easures
- escribe your patient popuation
- easures potted oer tie en if tere is ony one data point pot at you ae f you ae no data so o you oud set up your grap
- nforation about your registry

30 IN 0 IN IININ

HAVE

Additional Suggestions for the Storyboard:

- Provide a brief description of your clinic and health plan partner (if you are partnering with a health plan).
- Record your team name, with team members and their titles.
- State your **aim** for the Collaborative that coincides with the data you are presenting. Also, note the pilot site/population your efforts are focused on – is it one site, or the whole clinic organization, for example.
- Include the **measures** you will use throughout the Collaborative. These measures should support your aim.
- Summarize your progress in establishing a **registry**.
- If necessary, limit your storyboard to one or two **run charts** that are most important to gauge your progress in measuring your aim. If you have baseline or historical data, please include it. If not, just show how you would set up the chart; data is not necessary. Run charts should have titles that are brief but explain the significance of the data. Remember to label your charts on the x and y-axis and include annotations if necessary. It helps the reader if you use actual dates (Feb 2001, Mar 2001) rather than "Month 1" and always include your baseline measurement. Although the data in February will be very early, if changes were implemented, identify them on the chart, if appropriate, in an informative way. For example, instead of writing, “re-designed medical record” state “instituted flow chart.”

A short **summary** is helpful for the uninitiated reader. An appropriate statement might be, "During a 6-week period, a registry was established. The average HbA1c measurement baseline of 9.2 percent was established for all of the 65 patients with Diabetes at the Fort Greene site."

Accessing the Collaborative's Communication System (Website and Listserv)

Electronic communication will be a major mode of communication among faculty and participants during the course of the Collaborative. Electronic mail will be used to disseminate information to participants, ask questions of and receive replies from faculty and participants, and conduct ongoing discussions of content. In addition to individual correspondence via email and listserv, PRO-West and DOH will manage a website for the Collaborative. All teams should access and explore the website prior to the first Learning Session. Collaborative's Website address is: http://www.doh.wa.gov/cfh/wsdc. What is posted here now is from WSDC I. Forms will be available at Learning Session I to sign up for the listserv. At least one member from each team will be expected to sign up for the listserv; however, we encourage all team members to sign up.

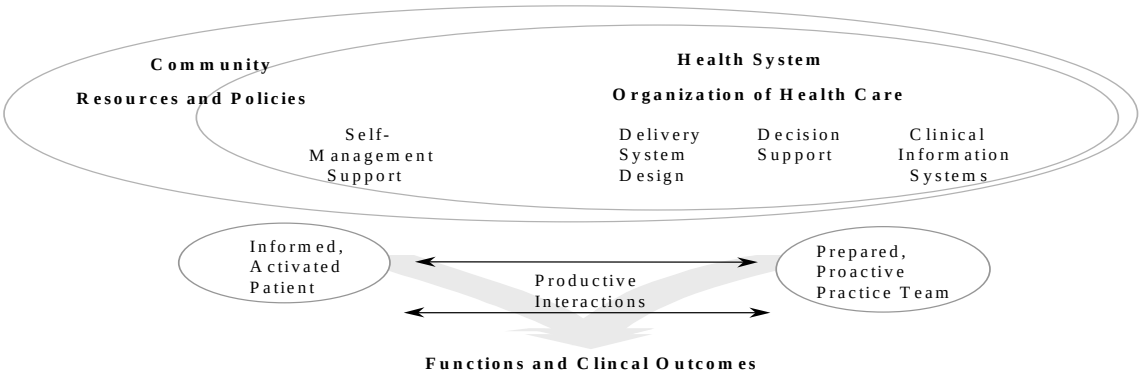
APPENDIX A

Chronic Care Model

Chronic Care Model

An organizational approach to caring for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, evidenced-based interactions between an informed, activated patient and a prepared, proactive practice team.

Chronic Care Model



Health Care Organization

- Goals for chronic illnesses are a measurable part of the organization's annual business plan.
- Benefits that health plans provide are designed to promote good chronic illness care.
- Provider incentives are designed to improve chronic illness care.
- Improvement strategies that are known to be effective are used to achieve comprehensive system change.
- Senior leaders visibly support improvement in chronic illness care.

Community Resources and Policies

- Effective programs are identified and patients are encouraged to participate.
- Partnerships with community organizations are formed to develop evidence-based programs and health policies that support chronic care.
- Health plans coordinate chronic illness guidelines, measures and care resources throughout the community.

Self-management Support

- Providers emphasize the patient's active and central role in managing their illness.
- Standardized patient assessments include self-management knowledge, skills, confidence, supports, and barriers.
- Effective behavior change interventions and ongoing support with peers or professionals are provided.
- Collaborative care-planning and assistance with problem-solving are assured by the care team.

Decision Support

- Evidence based guidelines are embedded into daily clinical practice.
- Specialist expertise is integrated into primary care.
- Provider education modalities proven to change practice behavior are utilized.
- Patients are informed of guidelines pertinent to their care.

Delivery System Design

- Team roles are defined and tasks delegated.
- Planned visits are used to provide care.
- Continuity is assured by the primary care team.
- Regular follow-up is ensured.

Clinical Information Systems

- There is a registry with clinically useful and timely information.
- Care reminders and feedback for providers and patients are built into the information system.
- Relevant patient subgroups can be identified for proactive care.
- Individual patient care planning is facilitated by the information system.

APPENDIX B

Assessment of Chronic Illness Care Survey, Version III

Assessment of Chronic Illness Care

Version 3 for Washington State Diabetes Collaborative II

Please complete the following information about you and your organization. This information will not be disclosed to anyone besides the Washington State Diabetes Collaborative and the Improving Chronic Illness Care[1] team. Please also indicate the names of persons (e.g., team members) who complete the survey with you. Later on in the survey, you will be asked to describe the process by which you complete the survey.

Your name: Team name:	Date: _____/_____/_____ **Month Day Year**
Organization & Address:	Names of other persons completing the survey with you: **1.**
	2.
	3.
Your phone number: **(_____) __ __ __ - __ __ __ __**	Your e-mail address:

[1] Improving Chronic Illness Care is a national program of the Robert Wood Johnson Foundation at the MacColl Institute for Healthcare Innovation in the Center for Health Studies at Group Health Cooperative of Puget Sound.

Directions for Completing the Survey

This survey is designed to help systems and provider practices move toward the "state-of-the-art" in managing chronic illness. The results can be used to help your team identify areas for improvement. Instructions are as follows:

1. **Answer each question** from the perspective of your pilot site (e.g., a practice, clinic, hospital, health plan) that supports care for chronic illness.

2. For each row, **circle the point value** that best describes the level of care that currently exists in the pilot site. The rows in this form present key aspects of chronic illness care. Each aspect is divided into levels showing various stages in improving chronic illness care. The stages are represented by points that range from 0 to 11. The higher point values indicate that the actions described in that box are more fully implemented.

3. **Sum the points in each section** (e.g., total part 1 score), calculate the average score (e.g., total part 1 score / # of questions), and enter these scores in the space provided at the end of each section. Then sum all of the section scores and complete the average score for the program as a whole by dividing this by 28.

For more information about how to complete the survey, please contact Donna M. Daniel, PhD at telephone: 206.364.9700 x2376 or email: donnad@pro-west.org.

Fax or mail your completed survey to

Donna M. Daniel, Ph.D.
PRO-West
10700 Meridian Avenue North
Suite 100
Seattle, WA 98133

FAX: 206.368.2419

Assessment of Chronic Illness Care, Version 3

Part 1: Organization of the Healthcare Delivery System. Chronic illness management programs can be more effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on chronic illness care.

Components	Level D	Level C	Level B	Level A
Overall Organizational Leadership in Chronic Illness Care	…does not exist or there is a little interest.	…is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work.	…is reflected by senior leadership and specific dedicated resources (dollars and personnel).	…is part of the system's long term planning strategy, receive necessary resources, and specific people are held accountable.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Organizational Goals for Chronic Care	…do not exist or are limited to one condition.	…exist but are not actively reviewed.	…are measurable and reviewed.	…are measurable, reviewed routinely, and are incorporated into plans for improvement.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Improvement Strategy for Chronic Illness Care	…is ad hoc and not organized or supported consistently.	…utilizes ad hoc approaches for targeted problems as they emerge.	…utilizes a proven improvement strategy for targeted problems.	…includes a proven improvement strategy and uses it proactively in meeting organizational goals.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Incentives and Regulations for Chronic Illness Care	…are not used to influence clinical performance goals.	…are used to influence utilization and costs of chronic illness care.	…are used to support patient care goals.	…are used to motivate and empower providers to support patient care goals.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Senior Leaders	…discourage enrollment of the chronically ill.	…do not make improvements to chronic illness care a priority.	…encourage improvement efforts in chronic care.	…visibly participate in improvement efforts in chronic care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Benefits	…discourage patient self-management or system changes.	…neither encourage nor discourage patient self-management or system changes.	…encourage patient self-management or system changes.	…are specifically designed to promote better chronic illness care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Health Care Organization Score _____ Average Score (Health Care Org. Score / 6) _____

Part 2: Community Linkages. Linkages between the health delivery system (or provider practice) and community resources play important roles in the management of chronic illness.

Components	Level D	Level C	Level B	Level A
Linking Patients to Outside Resources **Score**	…is not done systematically. 0 1 2	…is limited to a list of identified community resources in an accessible format. 3 4 5	…is accomplished through a designated staff person or resource responsible for ensuring providers and patients make maximum use of community resources. 6 7 8	… is accomplished through active coordination between the health system, community service agencies and patients. 9 10 11
Partnerships with Community Organizations **Score**	…do not exist. 0 1 2	…are being considered but have not yet been implemented. 3 4 5	…are formed to develop supportive programs and policies. 6 7 8	…are actively sought to develop formal supportive programs and policies across the entire system. 9 10 11
Regional Health Plans **Score**	…do not coordinate chronic illness guidelines, measures or care resources at the practice level. 0 1 2	…would consider some degree of coordination of guidelines, measures or care resources at the practice level but have not yet implemented changes. 3 4 5	…currently coordinate guidelines, measures or care resources in one or two chronic illness areas. 6 7 8	…currently coordinate chronic illness guidelines, measures and resources at the practice level for most chronic illnesses. 9 10 11

Total Community Linkages Score _____ Average Score (Community Linkages Score / 3) _____

Part 3: Practice Level. Several components that manifest themselves at the level of the individual provider practice (e.g. individual clinic) have been shown to improve chronic illness care. These characteristics fall into general areas of self-management support, delivery system design issues that directly affect the practice, decision support, and clinical information systems.

Part 3a: Self-Management Support. Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness and reduce complications and symptoms.

Components	Level D	Level C	Level B	Level A
Assessment and Documentation of Self-Management Needs and Activities	…are not done.	…are expected.	…are completed in a standardized manner.	…are regularly assessed and recorded in standardized form linked to a treatment plan available to practice and patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Self-Management Support	…is limited to the distribution of information (pamphlets, booklets).	…is available by referral to self-management classes or educators.	…is provided by trained clinical educators who are designated to do self-management support, affiliated with each practice, and see patients on referral.	…is provided by clinical educators affiliated with each practice, trained in patient empowerment and problem-solving methodologies, and see most patients with chronic illness.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Addressing Concerns of Patients and Families	…is not consistently done.	…is provided for specific patients and families through referral.	…is encouraged, and peer support, groups, and mentoring programs are available.	…is an integral part of care and includes systematic assessment and routine involvement in peer support, groups or mentoring programs.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Effective Behavior Change Interventions and Peer Support	…are not available.	…are limited to the distribution of pamphlets, booklets or other written information.	…are available only by referral to specialized centers staffed by trained personnel.	…are readily available and an integral part of routine care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Self-Management Score_____ Average Score (Self Management Score / 4) _____

Part 3b: Decision Support. Effective chronic illness management programs assure that providers have access to evidence-based information necessary to care for patients--decision support. This includes evidence-based practice guidelines or protocols, specialty consultation, provider education, and activating patients to make provider teams aware of effective therapies.

Components	Level D	Level C	Level B	Level A
Evidence-Based Guidelines **Score**	…are not available. 0 1 2	…are available but are not integrated into care delivery. 3 4 5	…are available and supported by provider education. 6 7 8	…are available, supported by provider education and integrated into care through reminders and other proven provider behavior change methods. 9 10 11
Involvement of Specialists in Improving Primary Care **Score**	…is primarily through traditional referral. 0 1 2	…is achieved through specialist leadership to enhance the capacity of the overall system to routinely implement guidelines. 3 4 5	…includes specialist leadership and designated specialists who provide primary care team training. 6 7 8	…includes specialist leadership and specialist involvement in improving the care of primary care patients. 9 10 11
Provider Education for Chronic Illness Care **Score**	…is provided sporadically. 0 1 2	…is provided systematically through traditional methods. 3 4 5	…is provided using optimal methods (e.g. academic detailing). 6 7 8	…includes training all practice teams in chronic illness care methods such as population-based management, and self-management support. 9 10 11
Informing Patients about Guidelines **Score**	…is not done. 0 1 2	…happens on request or through system publications. 3 4 5	…is done through specific patient education materials for each guideline. 6 7 8	…includes specific materials developed for patients which describe their role in achieving guideline adherence. 9 10 11

Total Decision Support Score_____ Average Score (Decision Support Score / 4) _____

Part 3c: Delivery System Design. Evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system focused on acute care. It may necessitate changes to the organization of practice that impact provision of care.

Components	Level D	Level C	Level B	Level A
Practice Team Functioning	…is not addressed.	…is addressed by assuring the availability of individuals with appropriate training in key elements of chronic illness care.	…is assured by regular team meetings to address guidelines, roles and accountability, and problems in chronic illness care.	…is assured by teams who meet regularly and have clearly defined roles including patient self-management education, proactive follow-up, and resource coordination and other skills in chronic illness care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Practice Team Leadership	…is not recognized locally or by the system.	…is assumed by the organization to reside in specific organizational roles.	…is assured by the appointment of a team leader but the role in chronic illness is not defined.	…is guaranteed by the appointment of a team leader who assures that roles and responsibilities for chronic illness care are clearly defined.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Appointment System	…can be used to schedule acute care visits, follow-up and preventive visits.	…assures scheduled follow-up with chronically ill patients.	…are flexible and can accommodate innovations such as customized visit length or group visits.	…includes organization of care that facilitates the patient seeing multiple providers in a single visit.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Follow-up	…is scheduled by patients or providers in an ad hoc fashion.	…is scheduled by the practice in accordance with guidelines.	…is assured by the practice team by monitoring patient utilization.	…is customized to patient needs, varies in intensity and methodology (phone, in person, email) and assures guideline follow-up.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Components	Level D	Level C	Level B	Level A
Planned Visits for Chronic Illness Care	…are not used.	…are occasionally used for complicated patients.	…are an option for interested patients.	…are used for all patients and include regular assessment, preventive interventions and attention to self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Continuity of Care	…is not a priority.	…depends on written communication between primary care providers and specialists, case managers or disease management companies.	…between primary care providers and specialists and other relevant providers is a priority but not implemented systematically.	…is a high priority and all chronic disease interventions include active coordination between primary care, specialists and other relevant groups.
Score	0 1 2	3 4 5	6 7 8	9 10 11

(From Previous Page)

Total Delivery System Design Score_____ Average Score (Delivery System Design Score / 6) _____

Part 3d: Clinical Information Systems. Timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that employ population-based approaches.[7, 8]

Components	Level D	Level C	Level B	Level A
Registry (list of patients with specific conditions)	…is not available.	…includes name, diagnosis, contact information and date of last contact either on paper or in a computer database.	…allows queries to sort sub-populations by clinical priorities.	…is tied to guidelines which provide prompts and reminders about needed services.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Reminders to Providers	…are not available.	… include general notification of the existence of a chronic illness, but does not describe needed services at time of encounter.	…includes indications of needed service for populations of patients through periodic reporting.	…includes specific information for the team about guideline adherence at the time of individual patient encounters.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Feedback	…is not available or is non-specific to the team.	…is provided at infrequent intervals and is delivered impersonally.	…occurs at frequent enough intervals to monitor performance and is specific to the team's population.	…is timely, specific to the team, routine and personally delivered by a respected opinion leader to improve team performance.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Information about Relevant Subgroups of Patients Needing Services	…is not available.	…can only be obtained with special efforts or additional programming.	…can be obtained upon request but is not routinely available.	…is provided routinely to providers to help them deliver planned care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Patient Treatment Plans	…are not expected.	…are achieved through a standardized approach.	…are established collaboratively and include self management as well as clinical goals.	…are established collaborative an include self management as well as clinical management. Follow-up occurs and guides care at every point of service.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Clinical Information System Score_____ Average Score (Clinical Information System Score / 5) _____

Briefly describe the process you used to fill out the form (e.g., reached consensus in a face-to-face meeting; filled out by the team leader in consultation with other team members as needed; each team member filled out a separate form and the responses were averaged).

Description: _____

_____

_____

Scoring Summary

(*Bring forward scoring at end of each section to this page)*

Total Org. of Health Care System Score _____

Total Community Linkages Score _____

Total Self-Management Score _____

Total Decision Support Score _____

Total Delivery System Design Score _____

Total Clinical Information System Score _____

Overall Total Program Score (sum of all scores) _____

Average Program Score (Total Program / 28) _____

What does it mean?

The overall average score provides an indication of the state of your organization's structures and processes that are supportive of good chronic illness care. It ranges from limited support to fully developed support of good chronic illness care. Average scores for individual parts can help you identify areas that your organization may wish to improve. Here are general guidelines to help you interpret your scores:

- Average score between 0 and 2 = Limited support for good chronic illness care
- Average score between 3 and 5 = Basic support of good chronic illness care
- Average score between 6 and 8 = Excellent support of good chronic illness care
- Average score between 9 and 11 = Fully developed support of good chronic illness care

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APPENDIX C

Sample Monthly Report for Diabetes Team

Sample Monthly Report for Diabetes Team

Organization: Rocky Road Clinic
Team: The A-1 Home Team
Date: May 2001

I. **Aim:**

Redesign the practice in all clinics in the health care system so that more than 90 percent of patients have an HbA1c less than 9.5 %; the blood pressure is less than 140/90 for 80% of the diabetes population; 70% of patients have an LDL cholesterol less than 130 mg/dl; and 70 percent of the diabetes patients have a patient self-management goal.

II. **Measures:**

Percentage of diabetes patients with the following documented goals and targets:

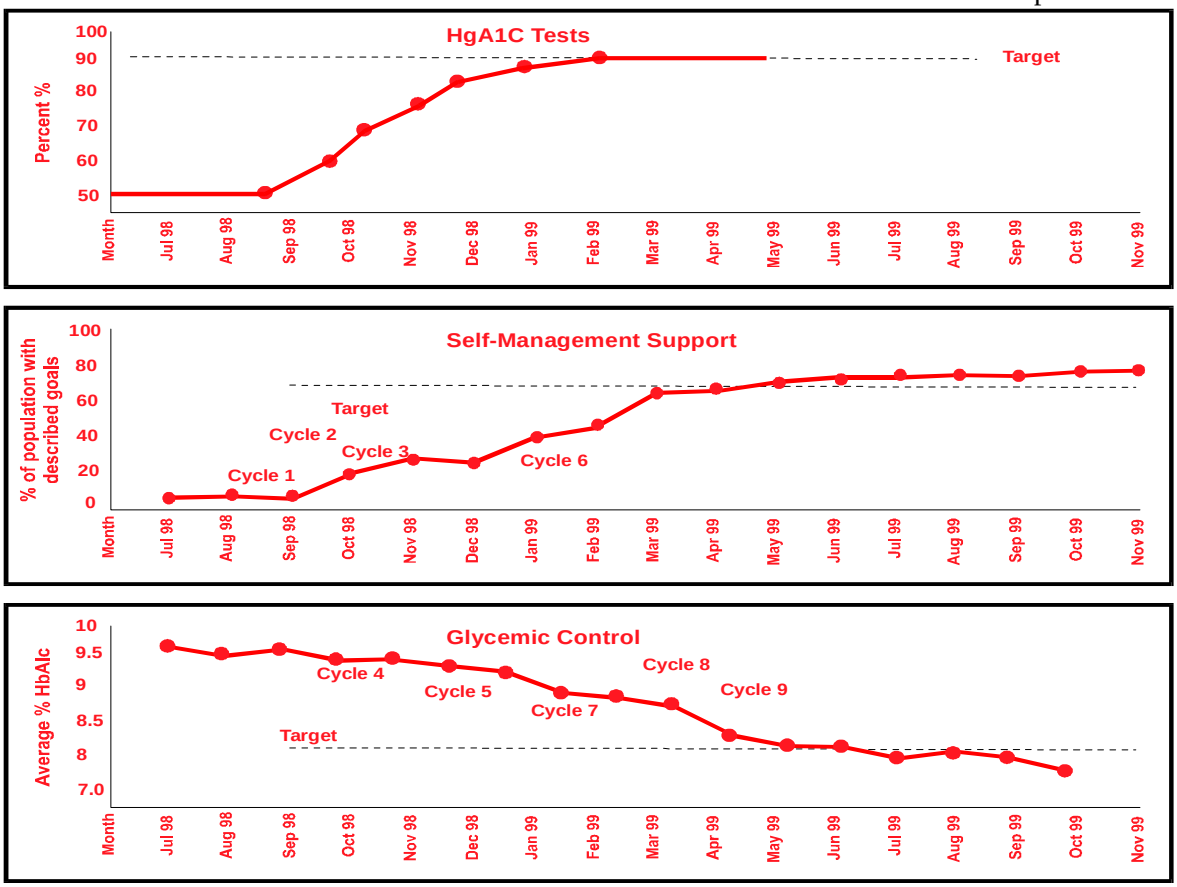
- An HbA1c below 9.5 %
- A blood pressure below 140/90
- An LDL cholesterol below 130 mg/dl
- A documented self-management goal

II. **Sampling Plan:**

Monthly analysis and summary of registry of diabetes patients.

IV. **Annotated Run Charts of Key Measure(s) This is a Corel Draw Graphic. I can't modify it.**

Below are sample run charts that give you an example of how your team's charts will look; however, adjustments to the dates and measures will need to be customized to meet the needs of this Collaborative. Resources and tools are available from the Collaborative Leadership Team.



V. Brief Description of Changes Tested (annotate on charts): Key Cycle's from the Chronic Care Model

Information System:

- Cycle 1: Establish registry
- Cycle 2: Begin summarizing measures monthly
- Cycle 3: Begin tracking progress
- Cycle 4: Developed registry reports to pro-actively follow-up with patients

Practice Re-design

- Cycle 1: Regular meetings of the diabetes care team have begun.
- Cycle 2: Offer choices for location and group visits
- Cycle 3: Implement new procedure for diabetes foot exam
- Cycle 4: Begin intervention program for foot exam for at risk patients

Patient Self-Management

- Cycle 1: Begin Collaborative goal-setting on visits with diabetes patients
- Cycle 2: Enroll appropriate patients in community weight loss programs

Clinical Decision Support

- Cycle 1: Communicate new guidelines for aspirin use

Community Resources

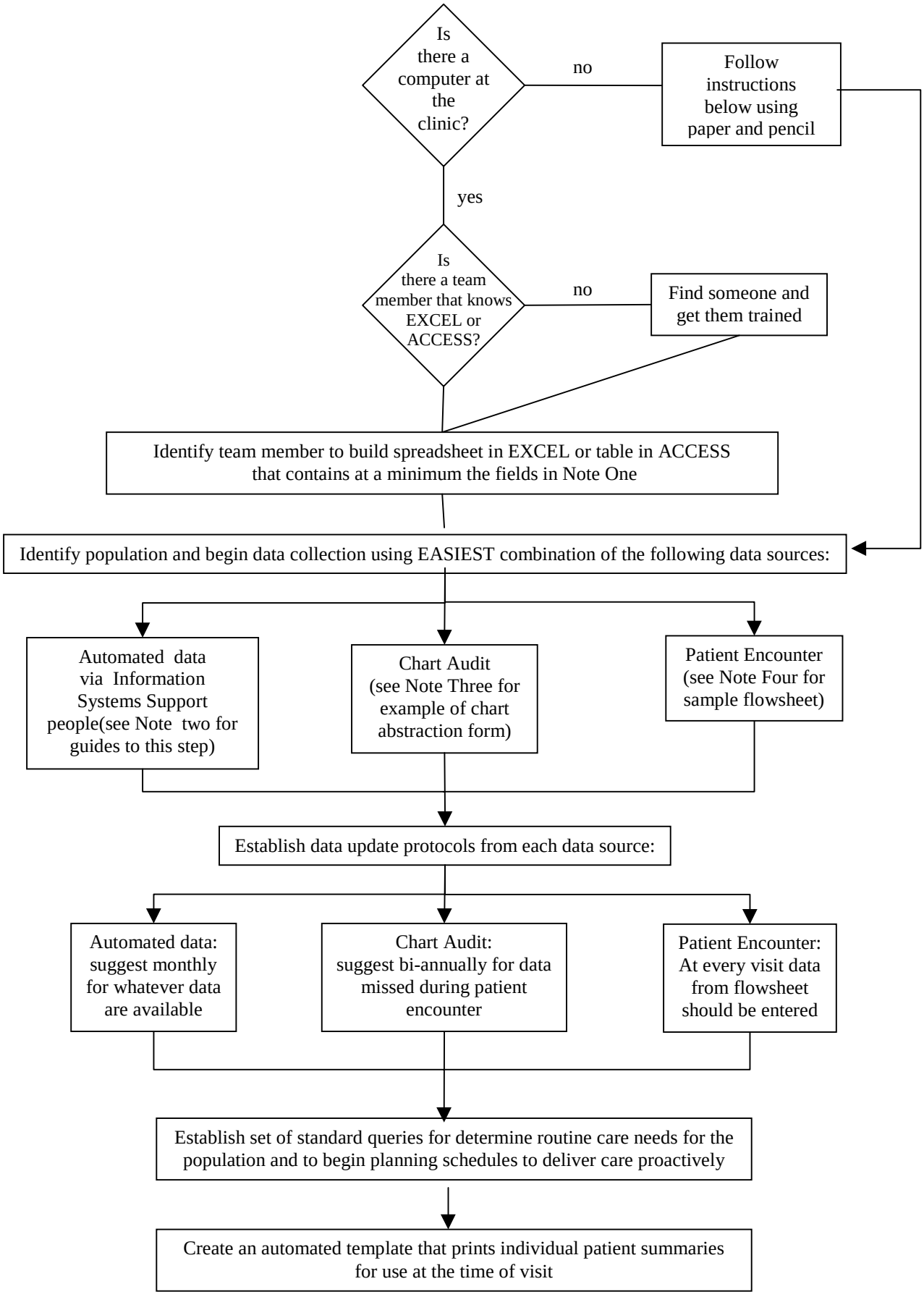
- Cycle 1: Link diabetes patients with community smoking cessation support groups

Summary of Results: Making good progress in practice redesign, but need to start grouping patients by similar complaints. Community Resources need a lot of work, will be discussing this at next team meeting.

APPENDIX D

Sample Diabetes Registry

Example: Constructing a Diabetes Registry

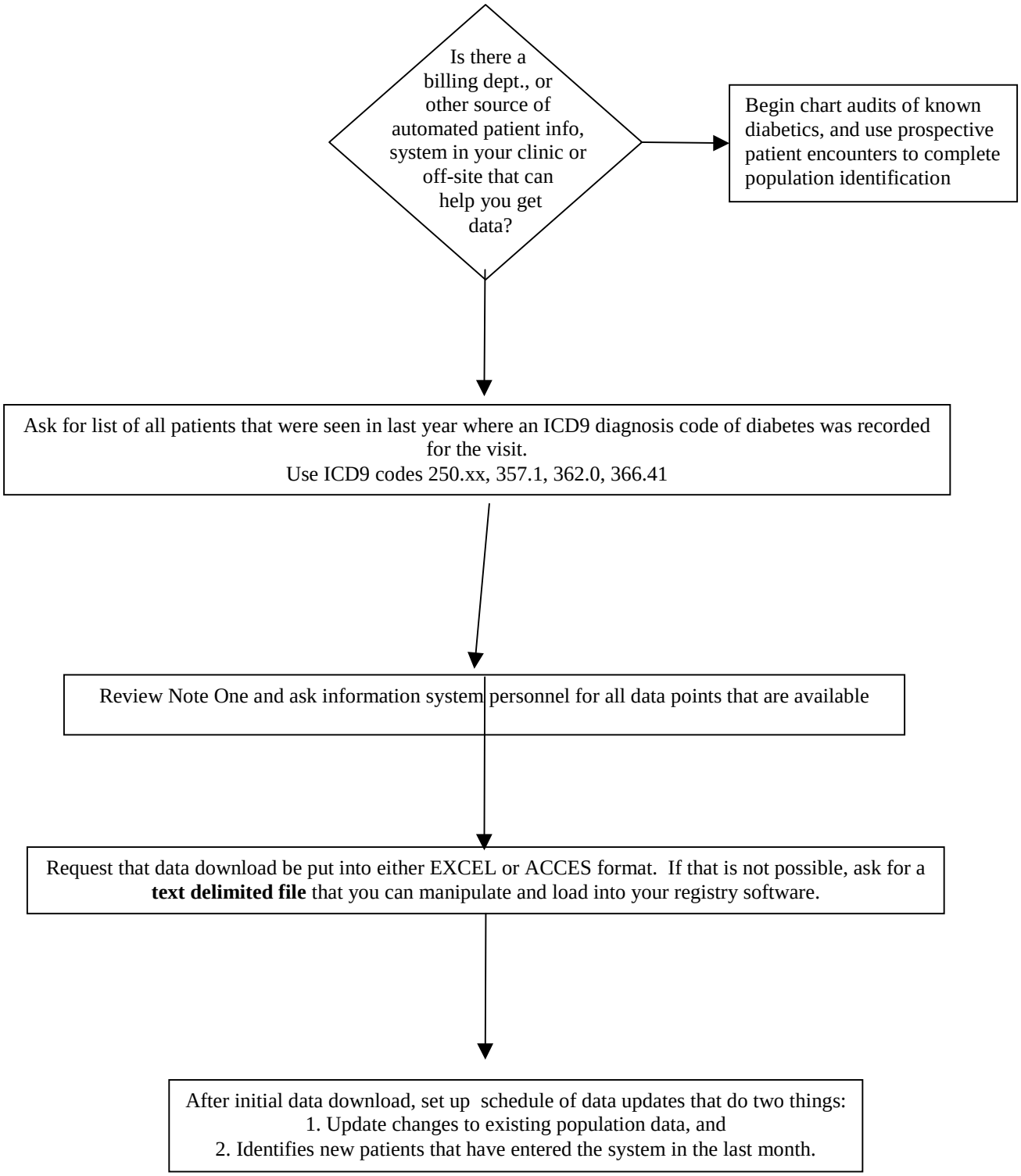


Note One: Fields to include in the Diabetes Registry

Your registry construction should strive to capture those data as you continually improve it. The list below suggests a minimum starting point for data capture.

Patient Identification Number
Patient Name (full name with Middle Initial)
Address (complete enough for mailing purposes)
Phone (home and work)
Gender
Date of Birth
Provider
Health Plan
Treatment Type (diabetes medications)
Other relevant medications (e.g, ACE inhibitors, aspirin, etc)
Comorbidities
Date of Last Glycosylated Hemoglobin
Result of Last Glycosylated Hemoglobin
Date of Last Total Cholesterol
Result of Total Cholesterol
Date of Last HDL
Result of Last HDL
Date of Last LDL
Result of LDL
Date of Last Microalbuminuria
Result of Last Microalbuminuria
Date of Last Blood Pressure
Result of Last Blood Pressure
Date of Last Retinal Exam
Eye Disease Status
Date of Last Foot Exam
Foot Risk Status (high or low)
Smoking Status
Evidence of Any Ongoing Patient Education (e.g., classes, instructional materials, etc.)
Has a Collaborative Self-management Support Plan Been Discussed (Yes/No)
Notes Associated with Collaborative Self-management Support Plan

Note Two: Getting Automated Data for the Registry



Note Three: Example of Chart Abstraction Form for Collecting Registry Data

DEMOGRAPHICS				
Today's Date				
Patient ID				
Patient Name				
Address		City	State	Zip
Phone	H:	W:		
Birth Date				
Gender				
PCP				
Health Plan				

	PAST	**MEDICAL**	**HISTORY**	
Comorbidities	CHF	COPD	Blind	Deafness
	Asthma	Stomach Probs	Arthritis/Rheum	Chronic Back Pain
	Hypertension	Angina	MI	Stroke
	Cancer	Kidney Disease	Sciaitic	

	PHYSICAL	**EXAM**	**VITALS**	
Smoking Status	Yes	No		
Last BP				
Last Weight				
Height				

MEDICATIONS
Insulin(s:)
Oral Agent(s):
ACE Inhibitor:
Other Relevant:

LABS		
Last A1c	Date:	Value:
Last Microalb.	Date:	Value:
Last Creatinine	Date:	Value:
Last Total Chol	Date:	Value:
Last HDL	Date:	Value:
Last LDL	Date:	Value:
Last TG	Date:	Value:

	ROUTINE	**DIABETES**	**CARE**
Last Eye Exam	Date:		Retinal Status:
Last Foot Exam	Date:		Foot Risk Status:

SELF	**MANAGEMENT**	**SUPPORT and**	**PATIENT**	**EDUCATION**
Ongoing Pt Ed?	Classes	Provider Visits	Other:	
Collab Plan?	Yes	No		
If yes, what are details of plan?				

Note Four: Example of Patient Encounter Form for Collecting Registry Data at Time of Visit (same form can be used as template for automated Patient Summary form for use during next visit)

Patient Summary Sheet

Date: Patient ID #: Patient Name: Patient Age: Primary Phone: Alternate Phone : Primary Practitioner	**Vital Signs** **Last Visit** **Today** Weight (Lbs) Height (Inches): Blood Pressure: Body Mass Index: Vital Signs Date: Smoking Status
Priority Registry Health Risk Factors	**Working Notes**
1. CAD/CVD Risk Family History of PREMATURE CAD? **Most Recent Lab Values** Total Chol____ HDL_____ TC/HDL _____ Date_____ LDL _____ Date_____ TG _____ Date_____ **Baseline LDL** Aspirin/day?	
2. Kidney Risks ***Albuminuria/Creat ratio Date:*** ***Serum Creatinine Date:***	
3. Retinal Screening Latest Eye Exam: Left Eye: Right Eye:	
4. Foot Risk Status Date of Last Foot Exam: High Risk Foot?	
5. Glycemic control HbA1c: Date: Frequency of SMBG: Shots/day: Insulin Dose:	
6. Cardiac/Diabetic Meds Niacin BAS/Fibrate Statin ACE Inhibitor Beta Blocker Diabetic Meds:	Changes:

APPENDIX E

Collaborative Glossary

Collaborative Glossary

Action Period
The period of time between Learning Sessions when teams work on improvement in their home organizations. They are supported by the Collaborative Leadership Team and faculty, and they are connected to other Collaborative Team Members.

Aim
A written, measurable, and time sensitive statement of the expected results of an improvement process.

Annotated Time Series
Synonym: Run Chart. A line chart showing results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur. This allows the viewer to connect changes made with specific results.

Assessment Scale
A numerical scale used to assess the progress of participating teams toward reaching their aim. 1= forming, and 5 = outstanding, sustainable improvement. In each Collaborative, teams are assessed monthly, and the expected level of attainment is a 4 (significant progress). Teams are asked to assess their own progress using this indicator as well.

Chair
The leader of the Collaborative, usually a nationally known expert in the topic.

Champion
Synonym: Clinical Champion. An individual in the organization who believes strongly in the improvements and is willing to try them and work with others to learn them. Teams need at least one clinical champion on their team; champions in other disciplines who work on the process are important as well.

Change Concept
A general idea for changing a process. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. "Simplify," "reduce handoffs," "consider all parties as part of the same system," are all examples of change concepts.

Chronic Care Model
An organized approach to caring for people with chronic disease in a primary care setting**.**

Collaborative
A time-limited effort (usually six to 12 months) of multiple organizations, which come together with faculty to learn about and to create, improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other, thus, "Everyone learns, everyone teaches."

Collaborative Team
Involves all participants from all clinics and/or health plan/clinic teams.

Coordinator
PRO-West staff person responsible for the day-to-day activities of the Collaborative, including meetings, materials, phone calls, website, reports, and information management.

Cycle or PDSA Cycle

A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes:
Plan- a specific planning phase,
Do-a time to try the change and observe what happens,
Study-an analysis of the results of the trial, and
Act-devising next steps based on the analysis.
This PDSA cycle will naturally lead to the Plan component of a subsequent cycle.

Day-to-Day Leader

The person on the organization team who is responsible for driving the improvement process every day. This person manages the team, arranges meetings, assures tests are being completed, and data are collected. Usually requires 0.25 FTEs or more to complete this role.

Diabetes Education Plan

An individualized plan developed by the patient and clinical team that includes eight major elements:

1. Appropriate assessment of the clinical, nutritional, social, and cultural needs;
2. Established short and long term goals;
3. Nutritional prescription/meal plan;
4. Exercise guidelines;
5. Blood glucose monitoring skills, if needed;
6. Skills to recognize and prevent hypoglycemia and manage diet during short-term illness;
7. Follow-up support, including avenues for rapid communication between the clinical team and patient; and
8. Medication management.

Director

The manager of a Collaborative who works with the faculty, teaches and coaches teams, and plans and executes Learning Session and Action Period activities.

Early Adopter

In the improvement process, the opinion leader within the organization who brings in new ideas from the outside, tries them, and uses experiences with positive results to persuade others in the organization to adopt the successful changes.

Early Majority/Late Majority

The individuals in the organization who will adopt a change only after it is tested by an early adopter (early majority) or after the majority of the organization is already using the change (late majority).

Implementation

Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

IS

Refers to the Information System in the organization, usually the computerized information system.

Key Changes

The list of essential process changes that will help lead to breakthrough improvement, usually created by the Leadership Team and Chair based on literature and their experiences.

Key Contact

The individual on the organization team who takes responsibility for communication between the team and PRO-West, including reporting monthly, and disseminating information to team members from the Institute. The Key Contact is often the day-to-day leader on the team.

Leadership Team

The small group of experts in the topic area who assist the Chair and Director in teaching and coaching participating teams. Usually the Leadership Team contains representatives from all the disciplines who are involved in the change process.

Learning Session

A two day meeting during which participating organization teams meet with faculty and collaborate to learn key changes in the topic area, including how to implement them, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes.

Listserv

Electronic computerized communication tool to broadcast information to a group of people.

Measure

Key measures should be focused, clarify your team's aim, and be reportable. A measure guides the ability to track patients for delivery of proven interventions, and to monitor their progress over time.

Model for Improvement

An approach to quality improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

Patient with Diabetes Mellitus (DM)

For purposes of the Diabetes Collaborative, patients with diabetes who have at least one visit to the clinic within the past calendar year are considered clinic patients unless there is documentation that the patient has transferred to another practice or has moved from the area. In addition, Clinics with managed care plans should try to include in the denominator, patients with diabetes who have **no** documented medical visit to the clinic, and who have been assigned to the clinic for 12 months, with no more than a 30 day drop in coverage.

PDSA

Another name for a cycle (structured trial) of a change, which includes four phases: Plan, Do, Study, and Act. See Cycle above. Sometimes known as Plan, Do, Check, Act (PDCA).

Pilot Site

The clinic location for focused changes. After implementation and refinement, the process will be spread to additional locations.

Population

Identifying the patient populations is the backbone to the population-based care delivery system. Without identification of the members of the sub-population, changes can not be achieved. To identify members, a clinic and/or health plan/clinic team needs to be able to access data that can distinguish populations with different health problems. ICD 9 or CPT codes from billing data are the most common source for making these distinctions.

Prework Packet

A book containing a complete description of the Collaborative, along with expectations and activities to complete prior to the first meeting of the Collaborative.

Prework Period

The time prior to the first Learning Session when teams prepare for their work in the Collaborative, including selecting team members, scheduling initial meetings, consulting with senior leaders, preparing their aim, and initiating data collection.

Process Change

A specific change in a process in the organization. More focused and detailed than a change concept, a process change describes what specific changes should occur. "Instituting a pain management protocol for patients with moderate to severe pain" is an example of a process change.

Run Chart

A graphic representation of data over time, also known as a "time series graph" or "line graph." This type of data display is particularly effective for process improvement activities.

Sampling Plan

A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. This is included on all Senior Leader reports. It emphasizes the importance of gathering samples of data to obtain "just enough" information

Self-management:

An on-going process for self-management goal setting with a patient that involves identification of barriers and challenges, personalized problem solving, and follow-up support. Important aspects of self-management include:

1. Basic disease-related knowledge and problem solving skills, such as interpreting symptoms, maintaining activities, managing medications, managing symptoms through relaxation, enjoyment of activities and exercise guidelines;
2. Managing uncertainty and emotions such as fear, and self-doubt;
3. Communication skills to build partnerships with the clinical team;
4. Understanding and use of community resources;
5. Mastery of skills needed to manage diabetes, including blood glucose and foot care monitoring skills;
6. Sharing ideas and learning from other patients with diabetes; and
7. Follow-up support, including avenues for rapid communication between the clinical team and the patient.

Senior Leader

The executive in the organization who supports the team and controls all the resources employed in the processes to be changed. This person is usually at the Senior Vice President level or higher. The Senior Leader works to connect the team's aim to the organization's mission, provides resources for the team, and promotes the spread of work of the team to others.

Senior Leader Report

The standard reporting format for monthly progress updates in a Collaborative. This concise two-page report includes an aim statement, measures to be used, a sampling plan, a listing of the changes made, and the results displayed graphically on annotated run charts. Report to be prepared by pilot team and sent to the Senior Leader and PRO-West.

Spread

The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on Diffusion of Innovation.

Team

The group of individuals, usually from multiple disciplines, that drive and participate in the improvement process. A core team of three individuals attend the Learning Sessions, but a larger team of six to eight people participate in the improvement process in the organization.

Technical Expert

The team member in the organization who has a strong understanding of the process to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.

Test

A small scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Washington State Diabetes Collaborative Outcomes Congress

A large public meeting after the Collaborative is completed, during which the best practices in the topic area are presented to others interested in making improvements in the area.

Website

A communication system that allows teams to stay connected with the Leadership Team and each other during the action periods. Sharing information, getting questions answered, and solving problems are all part of website activity.